

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

8159

08131

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glover Nursing Home Westminster, Md. R.D.4</b>		d. STREET ADDRESS <b>Westminster, Md. R.D.1</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Alverta</b> Last <b>Attlesperger</b>		4. DATE OF DEATH Month <b>8</b> Day <b>20</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1880</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Masonheimer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dutterer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Archie F. Tucker</b> Address <b>Archie F. Tucker, R.D.1, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration</b> DUE TO <b>8+ months</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 3, 1956</b> to <b>Aug 20, 1956</b> that I last saw the deceased alive on <b>Aug 20, 1956</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster, Md</b> DATE SIGNED <b>8/20</b>			
ACTUAL SIGNATURE <b>E. REESE WILKENS</b> M.D.			
PHYSICIAN'S NAME (Type) <b>E. REESE WILKENS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Union Mills, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR <b>8-23-56</b>	
ADDRESS <b>Littlestown, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>	

I have been thinking about you a lot lately.

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THE UNIVERSITY OF CHICAGO

BUREAU V. S.

AUG 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8160

## CERTIFICATE OF DEATH

Reg. Dist. No.

08132  
74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>16y.6mos. 26d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>unknown</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>BAILEY</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>August 27,</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1877</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ymk.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Ymk.</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>455X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia</b> DUE TO (c) <b>Gangrenous ulcer on upper back</b> INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Weeks</b> <b>Weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>50</b> , to <b>August 27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 27</b> , 19 <b>56</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Walther H. Sonnenfeldt</b> M.D. <b>Springfield State Hospital</b> <b>8/27/56</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-29-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rouken Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight - Sykesville, Md.</b>		24a. REC'D BY REGISTRAR <b>8-28-56</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weber</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Jan 15, 1955		10:00 AM		New York City		Dr. J. Smith		J. Doe	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		Hypertension		Jan 10, 1955		Jan 10, 1955		Jan 15, 1955		10:00 AM		New York City		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jan 15, 1955		10:00 AM		New York City		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith	

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# 1 8161 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

08133

74

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5 months</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				3. NAME OF DECEASED (Type or print) First Middle Last <b>HERBERT EDMUND BAKER</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3253 Chestnut Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/87</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi driver &amp; watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Benjamin Baker</b>			
14. MOTHER'S MAIDEN NAME <b>Elmira Krout</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>2 15-03-9118</b>				17. INFORMANT Address <b>Record, Springfield State Hospital, Sykesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome assoc. with CNS syphilis, meningo-encephalitic, with psychotic reaction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/7</b> , 19 <b>56</b> , to <b>8/29</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/29</b> , 19 <b>56</b> , and that death occurred at <b>1:25P approximately</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Alfred J. Shulman</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Alfred J. Shulman, M. D.</b>				DATE SIGNED <b>8/29/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 3, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR <b>4 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Heery</b>	



BUREAU V. S.

SEP 4 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08134

8162

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> 01022	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>311 Grand Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>----</u> Last <u>Becker</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-74</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>----</u> Days <u>----</u> Hours <u>----</u> Min. <u>----</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-hrs.</u> <u>15-yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis - agitated, depressed type</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-----</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>3-4-</u> , 19 <u>49</u> , to <u>8-13-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-13-</u> , 19 <u>56</u> , and that death occurred at <u>8:30PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hosp.</u> DATE SIGNED <u>8-13-56</u> ACTUAL SIGNATURE <u>Morrell N. Mastin</u> M.D. PHYSICIAN'S NAME (Type) <u>Morrell N. Mastin, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>---</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of M., Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>-----</u>		24a. REC'D BY REGISTRAR DATE <u>-----</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>		E-3.	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956 2 5

RECEIVED



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8163

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08135

CERTIFICATE OF DEATH

Reg. Dist. No. 88

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE E. BLACKSTEN</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 28 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/1888</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>CHARLES T. BLACKSTEN</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE POOLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>215-209201</u>			
17. INFORMANT <u>CARRIE F. BLACKSTEN</u> Address <u>NEW WINDSOR MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>56</u> , to <u>8/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/27</u> , 19 <u>56</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson M.D.</u> M.D. ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>8/28/56</u>							
PHYSICIAN'S NAME (Type) <u>M. E. Robertson</u> <u>NEW WINDSOR, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler &amp; Sons</u> ADDRESS <u>New Windsor Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 28/56</u>		24b. REGISTRAR'S SIGNATURE <u>G. W. S. Bandy</u>	

RECEIVED

AUG 30 1956

BUREAU V. A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD.  
CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*  
AGE: *45*  
SEX: *Male*  
RACE: *White*  
DATE OF BIRTH: *Jan 15, 1911*  
PLACE OF BIRTH: *Baltimore, Md.*  
OCCUPATION: *Teacher*  
EDUCATION: *High School Graduate*  
MARRIED: *Yes*  
SPOUSE: *Jane Doe*  
CAUSE OF DEATH: *Heart Disease*  
IMMEDIATE CAUSE: *Myocardial Infarction*  
UNDERLYING CAUSE: *Coronary Artery Disease*  
MANNER OF DEATH: *Natural*  
DATE OF DEATH: *Aug 25, 1956*  
PLACE OF DEATH: *Home*  
SIGNATURE OF PHYSICIAN: *Dr. J. K. Smith*  
SIGNATURE OF REGISTRAR: *John Doe*

RECEIVED  
DIVISION OF VITAL RECORDS  
AUG 30 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08136

8164

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster (Silver Run)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster (Silver Run)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.1</b>		d. STREET ADDRESS <b>Westminster, Md. R.D.1</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Catherine Bowman</b> First Middle Last		4. DATE OF DEATH <b>8/18/56</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/1869</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife, Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Schaeffer</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Morelock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Augustus Bowman</b> Address <b>Augustus Bowman, R.D.1, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>155X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF GALL BLADDER</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAY 22, 1956</b> , to <b>AUGUST 18, 1956</b> , that I last saw the deceased alive on <b>AUGUST 17, 1956</b> , and that death occurred at <b>5:15P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. R. Potter</b>		ADDRESS (Street, city or town, state) <b>Littlestown, Pa.</b> DATE SIGNED <b>8-19-56</b>	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>		<b>LITTLESTOWN, PA.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/21/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b> ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR <b>8-21-56</b>	24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. ONE

PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SPECIAL INSTRUCTIONS	
BALTIMORE, MARYLAND		JANUARY 1, 1900		MALE		WHITE		HIGH SCHOOL		LABORER		MARRIED		METHODIST			
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF INTERMENT			
BALTIMORE, MARYLAND		JANUARY 1, 1900		10:00 AM		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND		JANUARY 1, 1900		BALTIMORE, MARYLAND			
AGE		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SPECIAL INSTRUCTIONS			
100 YEARS		MALE		WHITE		HIGH SCHOOL		LABORER		MARRIED		METHODIST					
PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION			
BALTIMORE, MARYLAND		JANUARY 1, 1900		MALE		WHITE		HIGH SCHOOL		LABORER		MARRIED		METHODIST			
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF INTERMENT			
BALTIMORE, MARYLAND		JANUARY 1, 1900		10:00 AM		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND		JANUARY 1, 1900		BALTIMORE, MARYLAND			

BUREAU VI

AUG 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8165

CERTIFICATE OF DEATH

08137

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>-----</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>since 6/28/55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>Robert</u> Last <u>CLARKE</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1878</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--- 21 hr. ---</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CB with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>56</u> , to <u>August 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 3</u> , 19 <u>56</u> , and that death occurred at <u>8:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2/4/56</u>			
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D.			
PHYSICIAN'S NAME (Type) <u>EDMUND LUSTHAUS</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u>		22d. LOCATION (City, town, or county) (State) <u>Haymarket, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. D. Baker &amp; Son</u>		ADDRESS <u>Manassas, Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	



CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

AUG 9 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,12 FilmG201 8-17-56 et

## CERTIFICATE OF DEATH

08139

Reg. Dist. No.

8166

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				d. STREET ADDRESS <u>Unknown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> ??	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Colfield</u> Last <u>Colfield</u>			<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>12</u> Year <u>19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) yrs. <u>71??</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>None</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Miliary tuberculosis, bilateral, active, malnutrition</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	20g. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>8-4-</u> 19 <u>56</u> , to <u>8-12-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>8-12-</u> 19 <u>56</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8-14-56</u> ACTUAL SIGNATURE <u>T.F. Vestal</u> M.D. <u>Henryton, Maryland</u> PHYSICIAN'S NAME (Type) <u>Tom F. Vestal, M. D., Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of M., A. P.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank D. Newell, Picksville</u>			24a. REC'D BY REGISTRAR DATE <u>8-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Albert N. Swankhouse</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>Carroll</b>		2. SEX <b>Male</b>		3. AGE <b>68</b>	
4. DATE OF DEATH <b>Aug 15 1956</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>Home</b>	
7. OCCUPATION <b>Retired</b>		8. CAUSE OF DEATH <b>Heart Disease</b>		9. MANNER OF DEATH <b>Natural</b>	
10. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		11. SIGNATURE OF DECEASED <b>[Signature]</b>		12. SIGNATURE OF WITNESSES <b>[Signature]</b>	
13. SIGNATURE OF REGISTRAR <b>[Signature]</b>		14. SIGNATURE OF CLERK <b>[Signature]</b>		15. SIGNATURE OF CHIEF OF BUREAU <b>[Signature]</b>	

**RECEIVED**  
AUG 15 1956  
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808140

8167

## CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Woodbine</u>		LENGTH OF STAY (in this place) <u>20 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodbine</u> X			
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>50</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Edwin</u> <u>S.</u> <u>CONAWAY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>8 - 27</u> 19 <u>56</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>8 - 2 - 1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>owner</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William P. Conaway</u>				14. MOTHER'S MAIDEN NAME: <u>Clemetine Penn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Mamie Swanson, Woodbine, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Cardiac failure</u>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>20 years</u>	
(C) <u>Generalized arterio-sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 - 22</u> , 19 <u>56</u> , to <u>8 - 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8 - 25</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Bertrand R. Gau</u>		M. D. <u>Sykesville Md</u>		DATE SIGNED <u>8. 27. 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8-29-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug 28 1956</u>		REGISTRAR'S SIGNATURE <u>Robert P. Hurtt</u>		24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Md.</u>	

RECEIVED

AUG 30 1956

BUREAU V. 8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08141

8168

## CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH a. COUNTY <u>Winfield</u> <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winfield</u>	c. LENGTH OF STAY IN 1b <u>35 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winfield Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>none</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FTL BERTH</u> Middle <u>MABEL</u> Last <u>COOK</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>	
IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Native</u>	
13. FATHER'S NAME <u>Charles Cook</u>		14. MOTHER'S MAIDEN NAME <u>Essie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles Gibson</u>		Address <u>Wheaton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White Corneal Hemorrhage</u> <u>446x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Interstitial Nephritis</u> DUE TO (c) <u>Chr. General Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5</u> , 19 <u>55</u> , to <u>8/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Wheaton, Maryland</u> DATE SIGNED ACTUAL SIGNATURE <u>Arthur Bare</u> M.D. PHYSICIAN'S NAME (Type) <u>J. LUTHER BARE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll County</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Walz</u>		24a. REC'D BY REGISTRAR <u>14 1956</u>	
ADDRESS <u>Winfield, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Ernie Benedict</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
RECEIVED		AUG 14 1956	
BUREAU V. S.			

RECEIVED

AUG 14 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8169

## CERTIFICATE OF DEATH

Reg. Dist. No. 0814274

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3819 Reisterstown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Cox</b> Last <b>Cox</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-1875</b>
9. AGE (In years lost birthday) yrs. <b>81</b>		IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> HRS. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Kornmann</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smallwood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive psychosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-8</b> , 19 <b>56</b> , to <b>8-7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8-7</b> , 19 <b>56</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville, Maryland</b> DATE SIGNED <b>8/7/56</b>			
ACTUAL SIGNATURE <b>Alejandro P. Vicente</b> M.D.		PHYSICIAN'S NAME (Type) <b>ALEJANDRO P. VICENTE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-11-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc</b>		24a. REC'D BY REGISTRAR <b>10 1956</b>	
ADDRESS <b>1517 St Paul St</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Richard Lindenberg

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

34

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. WHITE		45		M		W		1880		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
AUG 10 1956		NEW YORK		NEW YORK		UNITED STATES		AUG 10 1956		NEW YORK		NEW YORK		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE		JAMES H. WHITE	

BUREAU V. S.

AUG 10 1956

RECEIVED

Check this

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8170

## CERTIFICATE OF DEATH

08143

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Md</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hinksburg</u>		TOWN <u>Hinksburg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hinksburg</u>		LENGTH OF STAY (in this place) <u>4 years</u>		STREET ADDRESS (If rural give location) <u>Deer Park Road</u>		TOWN <u>Hinksburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) <u>David</u> (Middle) <u>Elmer</u> (Last) <u>Dell</u>				<b>4. DATE OF DEATH</b> (Month) <u>Aug.</u> (Day) <u>31</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>June 2, 1873</u>	<b>9. AGE last birthday</b> <u>83</u> yrs.	<b>10. UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Nimrod Dell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Davis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-18-8755</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>M. Elmer Dell - Hinksburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Coronary thrombosis</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Arteriosclerosis</u>				<u>years</u>			
DUE TO (C) <u>Hypertension</u>				<u>years</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>  </u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>  </u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office, bldg., etc.) <u>  </u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21d. TIME OF INJURY</b> (Month) <u>  </u> (Day) <u>  </u> (Year) <u>  </u> (Hour) <u>  </u> (Min.) <u>  </u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>  </u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1-1-30</u> <b>19</b> <u>5</u> , <b>to</b> <u>8-31-</u> <b>19</b> <u>56</u> , <b>that I last saw the deceased alive on</b> <u>8-30-56</u> <b>and that death occurred at</b> <u>1:50</u> <b>P.M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James H. Seftel</u> <b>M.D.</b>				<b>ADDRESS</b> (Street, city, county, state) <u>Registerstown, Md 9-1-56</u> <b>DATE SIGNED</b> <u>  </u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9-3-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oakland</u>		<b>LOCATION</b> (City, town, or county) <u>Carroll Co. Md.</u> (State) <u>  </u>	
<b>24. REC'D BY REGISTRAR</b> <u>  </u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry Ween</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur A. Haigh - Hinksburg, Md.</u> <b>ADDRESS</b> <u>  </u>			
<b>DATE</b> <u>9-2-56</u>							



CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or type)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of burial

20. Signature of burial

21. Signature of burial

22. Signature of burial

23. Signature of burial

24. Signature of burial

25. Signature of burial

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42. Signature of burial

43. Signature of burial

44. Signature of burial

*Robert Thompson*  
*Robert Thompson*  
*Robert Thompson*

BUREAU V. 3

SEP 5 1956

RECEIVED

*Robert Thompson*

*James H. Laffey*  
*James H. Laffey*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08144

8171

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN 1b <b>3 mos., 15 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3429 University Place</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minnie Estelle Wallace DONALDSON</b>		4. DATE OF DEATH Month Day Year <b>August 16 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Wallace</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Reed</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1, 1956</b> , to <b>August 16, 1956</b> , that I last saw the deceased alive on <b>August 16, 1956</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 8/16/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/18/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montrose Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. J. Lickner &amp; Sons - Balto, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 17, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>C. Harry Shaw</b>

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

DATE OF BURIAL

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. S.

AUG 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hancock</i>			
c. LENGTH OF STAY IN 1b <i>29 hrs 17 days</i>				d. STREET ADDRESS <i>21x-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frances Katherine Donegan</i>				4. DATE OF DEATH Month Day Year <i>8 26 1956</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-29-1887</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Peter Yarnell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gramman</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>7144</i>		17. INFORMANT <i>Hospital records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>not known</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Manic-depressive reaction depressed type</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>11-10-</i> 19 <i>53</i> , to <i>8-26-</i> 19 <i>56</i> , that I last saw the deceased alive on <i>8-26-</i> 19 <i>56</i> , and that death occurred at <i>1:00</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i>				ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i>			
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>				DATE SIGNED <i>8/26/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-29-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cumberland</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Allen, Inc.</i>				ADDRESS <i>Cumberland, Md.</i>		24a. REC'D BY REGISTRAR <i>C. Harry Wheeler</i>	
24b. REGISTRAR'S SIGNATURE				DATE <i>8-27-56</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. PERIOD OF ILLNESS		14. PREVIOUS ILLNESS		15. PREVIOUS SURGERY	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

JUN 30 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8173

## CERTIFICATE OF DEATH

08146

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>15y; 4mos.; 6days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Gussie</b> Middle <b>O.</b> Last <b>DUSING</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1897</b>
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Cora Griffin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Megacolon of unknown cause</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with mental deficiency.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>50</b> , to <b>August 9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 9</b> , 19 <b>56</b> , and that death occurred at <b>6:00 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		DATE SIGNED <b>8/10/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>--</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U. of M., Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Sonnenfeldt</b>		24a. REC'D BY REGISTRAR DATE <b>C. Harry Weir</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weir</b>		e-j.	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF CLERGYMAN [Illegible]		NAME OF FUNERAL HOME [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF BURIAL PLACE [Illegible]		NAME OF CEMETERY [Illegible]	
NAME OF MINISTER [Illegible]		NAME OF CHURCH [Illegible]		NAME OF SOCIETY [Illegible]	
NAME OF DECEASED'S MOTHER [Illegible]		NAME OF DECEASED'S FATHER [Illegible]		NAME OF DECEASED'S SPOUSE [Illegible]	
NAME OF DECEASED'S BROTHER [Illegible]		NAME OF DECEASED'S SISTER [Illegible]		NAME OF DECEASED'S CHILD [Illegible]	
NAME OF DECEASED'S GRANDFATHER [Illegible]		NAME OF DECEASED'S GRANDMOTHER [Illegible]		NAME OF DECEASED'S UNCLE [Illegible]	
NAME OF DECEASED'S AUNT [Illegible]		NAME OF DECEASED'S NEPHEW [Illegible]		NAME OF DECEASED'S NIECE [Illegible]	
NAME OF DECEASED'S COUSIN [Illegible]		NAME OF DECEASED'S FIRST COUSIN [Illegible]		NAME OF DECEASED'S SECOND COUSIN [Illegible]	
NAME OF DECEASED'S THIRD COUSIN [Illegible]		NAME OF DECEASED'S FOURTH COUSIN [Illegible]		NAME OF DECEASED'S FIFTH COUSIN [Illegible]	
NAME OF DECEASED'S SIXTH COUSIN [Illegible]		NAME OF DECEASED'S SEVENTH COUSIN [Illegible]		NAME OF DECEASED'S EIGHTH COUSIN [Illegible]	
NAME OF DECEASED'S NINTH COUSIN [Illegible]		NAME OF DECEASED'S TENTH COUSIN [Illegible]		NAME OF DECEASED'S ELEVENTH COUSIN [Illegible]	
NAME OF DECEASED'S TWELFTH COUSIN [Illegible]		NAME OF DECEASED'S THIRTEENTH COUSIN [Illegible]		NAME OF DECEASED'S FOURTEENTH COUSIN [Illegible]	
NAME OF DECEASED'S FIFTEENTH COUSIN [Illegible]		NAME OF DECEASED'S SIXTEENTH COUSIN [Illegible]		NAME OF DECEASED'S SEVENTEENTH COUSIN [Illegible]	
NAME OF DECEASED'S EIGHTEENTH COUSIN [Illegible]		NAME OF DECEASED'S NINETEENTH COUSIN [Illegible]		NAME OF DECEASED'S TWENTIETH COUSIN [Illegible]	

BUREAU V. 2

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8174

## CERTIFICATE OF DEATH

08147

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fishersville</i>	c. LENGTH OF STAY IN 1b <i>30 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fishersville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Fishersville P.O.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>BESSIE L DYKES</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>3</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12, 1892</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Delaware</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Raymond E. Wiley</i>		14. MOTHER'S MAIDEN NAME <i>Laura North</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Wm C. Dykes - Fishersville, Md.</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Hypertension - 180X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized metabolism, anemia -</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1954</i> <i>Aug 56</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1954</i> , 19____, to <i>3 Aug</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3 Aug</i> , 19 <i>56</i> , and that death occurred at <i>8 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Fishersville, Md</i> DATE SIGNED <i>3 Aug 56</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>Sikesville, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-6-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Freedom</i>	22d. LOCATION (City, town, or county) (State) <i>Fishersville Rd. Carroll Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i> ADDRESS <i>Fishersville, Md</i>		24a. REC'D BY REGISTRAR <i>DATE 8-4-56</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Wear</i>

BUREAU V. S.

Aug 6 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08148

Reg. Dist. No. 78

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> c. LENGTH OF STAY IN lb <u>14 to -</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Weinert's Boarding House</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FENTON</u> Middle <u>B</u> Last <u>ENGLAR</u>				<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>15</u> Year <u>1956</u>			
<b>5. SEX</b> <u>m</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 12-1882</u> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>FRANK J. ENGLAR</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>MINNIE DEVLIN BISS</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Frank J. Englar</u> Address <u>Union Bridge Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <u>Arterio sclerotic Cardiovascular</u> <u>422.1</u> <b>DUE TO</b> _____ <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) _____ <b>DUE TO</b> _____ (c) _____ <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>years</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____				<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour o. m. _____ p. m. _____			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input "="" checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>8/16/56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>JAMES T. MARSH</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>8/19/56</u>			
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Piper Creek Cem.</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Carroll County, Md</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Old Hartman Bros New Windsor</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Harriet Miller</u> <b>DATE</b> <u>8-18-56</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> _____				<b>24c. REGISTRAR'S SIGNATURE</b> _____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

8156

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>49 W. Main St.</b>		d. STREET ADDRESS <b>49 W. Main St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jennie May Belle Fowble</b>		4. DATE OF DEATH Month Day Year <b>August 8 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1874</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James A. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Sarah LaMotte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	
17. INFORMANT <b>H. Donald Fowble</b>		Address <b>Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>a.s.c.v. disease</b> (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		DATE SIGNED <b>8/8/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Uniontown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR <b>8-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harold Miller</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased George J. Carroll		Age 60 years	
Sex Male		Race White	
Date of Birth May 12, 1914		Place of Birth Towson, Maryland	
Date of Death May 13, 1956		Place of Death Towson, Maryland	
Cause of Death Heart Disease		Manner of Death Natural	
Signature of Medical Examiner James A. Smith		Signature of Coroner H. Towson	

BUREAU V. S.

AUG 13 1956

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Signature of Coroner John R. Evans		Signature of Medical Examiner James A. Smith	
Date May 13, 1956		Place Towson, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8176

CERTIFICATE OF DEATH

Reg. Dist. No.

08150  
74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN b <b>27 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>6825 Pinlico</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>GAMERMAN</b> Last <b>GAMERMAN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March, 1882</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Henry Gamerman</b>				14. MOTHER'S MAIDEN NAME <b>Rose Libuwitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Springfield Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastasis to lung</b> DUE TO (b) <b>Pulmonary tuberculosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>002X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>1 yr. -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. asso. with cerebral arteriosclerosis with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 3, 1956</b> , to <b>August 30, 1956</b> , that I last saw the deceased alive on <b>August 30, 1956</b> , and that death occurred at <b>7:30P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 8/31/56</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kneseth Israel Anshe Sfard</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Perinson Inc</b> ADDRESS <b>1124-26 W. North Ave</b>				24a. REC'D BY REGISTRAR <b>SEP 4 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Shays</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
Maryland		Male		30		1925		Baltimore		Maryland		United States		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
1956		10:30 AM		Home		Baltimore		Maryland		United States		Heart Disease		Natural	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOW		DIVORCED	
Teacher		High School		Catholic		Single		Single		Single		Single		Single	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER		SIGNATURE OF OTHER		SIGNATURE OF OTHER		SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
1956		10:30 AM		Home		Baltimore		Maryland		United States		Heart Disease		Natural	

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SEP 4 1956

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1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8177  
CERTIFICATE OF DEATH

08151

Reg. Dist. No. 76

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Mills</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deep Run Road</b>		d. STREET ADDRESS <b>Deep Run Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Margaret</b> Last <b>Gary</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>3,</b> Year <b>19 56.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1876</b>
9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John G. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Harry I. Penrod, Union Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Block</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>3 hrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 3, 1956</b> , to <b>Aug 3, 1956</b> , that I last saw the deceased alive on <b>Aug 3, 1956</b> , and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>23 North Main St Manchester, Md.</b> DATE SIGNED <b>8/3/56</b>			
ACTUAL SIGNATURE <b>W. H. Foard</b> M.D.			
PHYSICIAN'S NAME (Type) <b>W. H. Foard M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-6-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Howard Strong</b>		24a. REC'D BY REGISTRAR <b>Aug 5 1956</b>	
ADDRESS <b>307 W. North Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death		Place of Death	
August 1, 1956		Detroit, Michigan	
Age		Sex	
38 years		Male	
Race		Marital Status	
Caucasian		Married	
Occupation		Cause of Death	
Engineer		Heart Disease	
Date of Birth		Place of Birth	
August 1, 1918		Detroit, Michigan	
Date of Death		Place of Death	
August 1, 1956		Detroit, Michigan	
Age		Sex	
38 years		Male	
Race		Marital Status	
Caucasian		Married	
Occupation		Cause of Death	
Engineer		Heart Disease	
Date of Birth		Place of Birth	
August 1, 1918		Detroit, Michigan	

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8178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (2.1)</b> <b>03-54-2</b>	
c. LENGTH OF STAY IN 1b <b>12y; lmo.; 11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>222 N. Marlyn Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Edward</b> Last <b>GOFF</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1905</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Paul Goff</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Goff -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>002X Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, hebephrenic type</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs. plus</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 19 50</b> to <b>August 10, 19 56</b> , that I last saw the deceased alive on <b>August 9, 19 56</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>8/13/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Homes - I30 E. Fort Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>8-10-56</b>	24b. REGISTRAR'S SIGNATURE <b>C. Harry Wan</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. Name of deceased                  [Illegible]</p>		<p>2. Date of death                  [Illegible]</p>	
<p>3. Place of death                  [Illegible]</p>		<p>4. Cause of death                  [Illegible]</p>	
<p>5. Age at death                  [Illegible]</p>		<p>6. Sex                  [Illegible]</p>	
<p>7. Race                  [Illegible]</p>		<p>8. Marital status                  [Illegible]</p>	
<p>9. Occupation                  [Illegible]</p>		<p>10. Date of birth                  [Illegible]</p>	
<p>11. Place of birth                  [Illegible]</p>		<p>12. Signature of physician                  [Illegible]</p>	
<p>13. Signature of registrar                  [Illegible]</p>		<p>14. Date of registration                  [Illegible]</p>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08153  
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 yrs; 3 mos. 11 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>-</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wilhelmina</b> Middle <b>Hanson</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>80 1/2 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None -</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Christian Hanson</b>	
14. MOTHER'S MAIDEN NAME <b>Emily Yedaker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT Address <b>Springfield Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture right hip</b> DUE TO (c) <b>Decubitus ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>21 days</b> <b>21 da. plus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia praecox</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off a bench.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:30 a.m. 7/20/ 56</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/10/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>8-13-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Hignett</b>		ADDRESS <b>Ellicott City, Md</b>	
24a. REG'D BY REGISTRAR <b>8-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Wood</b>	



BUREAU V. S.

AUG 13 1956

8180

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>23y; 10m; 24da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>11 N. Jonathan Street</b>			
3. NAME OF DECEASED (Type or print) <b>Ralph</b> First <b>HOFFMAN</b> Middle Last				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b>	9. AGE (In years lost birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>C. Knode Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Bessie M. Sechrest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, hebephrenic type</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>August 21, 1956</b> , that I last saw the deceased alive on <b>August 21, 1956</b> , and that death occurred at <b>3:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/21/56</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM. Hagerstown Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.K. Hoffman</b>				24a. REC'D BY REGISTRAR <b>Hagerstown Md</b>		24b. REGISTRAR'S SIGNATURE <b>DATE 8/23/56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

8181 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

08155

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>22y; 2mos; 11days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Nellie D. HOOTEN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2549 Garrett Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Day Year <b>August 9 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/69</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel G. Hooten</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Sawtell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO 423.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>904.7</b> (b) <b>Infected Decubitus Ulcer on Back</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease. Mental Deficiency without psychosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Slipped and fell</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>9:30 a.m. 7/10 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield Hosp.</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>August 9, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickens &amp; Sons - Balto. Md.</b>		24. REC'D BY REGISTRAR DATE <b>AUG 10 1956</b>	
ADDRESS <b>Balto. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Kees</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

8182

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08156  
Reg. Dist. No. 75

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millers (Aleshia)</b>		c. LENGTH OF STAY IN lb <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millers (Aleshia)</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Idlet Sr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1956</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-88</b> <b>Aug 15, 1956</b>			
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Prod. Manager - Md Bk Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kansas</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Idlet</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Vincent</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>215-10-9135</b>		17. INFORMANT Address <b>Mrs John Idlets Sr. Millers, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suicide by gunshot wound of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis- Gastric Ulcer healed- Emphysema Pulmonary</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18-1) <b>Self inflicted gunshot wound of head</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>2A. Mo. Aug 15, 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Millers Aleshia Carroll, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>W. H. Foard</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>8/15/56</b>	
EXAMINER'S NAME (Type) <b>W. H. Foard M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manchester</b>		22d. LOCATION (City, town or county) (State) <b>Carroll Co Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw &amp; Tipton Humpstead Md</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Aug 17-56</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. P. Deane</b>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8183

CERTIFICATE OF DEATH

08157  
 Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>North Carolina</i> b. COUNTY <i>Edgecombe Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westmount</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rocky Mount, R.D. #2</i>	
c. LENGTH OF STAY IN 1b <i>9 weeks</i>		d. STREET ADDRESS <i>70X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Chapel</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>JONES</i> Last <i>JONES</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>29</i> Year <i>1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1886</i>
9. AGE (In years last birthday) <i>70</i>		10. IF UNDER 1 YEAR Months <i>29</i> Days <i>29</i> Hours <i>29</i> Min. <i>29</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rocky Mount N.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ned Lewis</i>		14. MOTHER'S MARDEN NAME <i>Samuel Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mr. David Perry, Westmount Md R.D.</i>		Address <i>Westmount Md R.D.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial degeneration</i> <i>422.11</i> DUE TO <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>no</i> DUE TO (c) <i>no</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>no</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-19-1956</i> to <i>8-29-1956</i> that I last saw the deceased alive on <i>8-2-1956</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Westmount Md</i> DATE SIGNED <i>8/29</i>			
ACTUAL SIGNATURE <i>E. Reese Wilkens</i> M.D.		DATE SIGNED <i>8/29</i>	
PHYSICIAN'S NAME (Type) <i>E REESE WILKENS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>Sept. 1, 56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mark's Chapel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Rocky Mount, N.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr.</i> ADDRESS <i>Westmount, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 8-29-56</i>	
		24b. REGISTRAR'S SIGNATURE <i>J. H. Miller</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

#8, Film G508 10/16/85 kam

CERTIFICATE OF DEATH

08158

Reg. Dist. No.

82-83

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gosnell Nursing Home</b>		d. STREET ADDRESS <b>Woodbine</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE WARRINGTON KEES</b>		4. DATE OF DEATH Month Day Year <b>AUG. 21 1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1879 Nov. 10, 1880</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas Taitt Blood</b>		14. MOTHER'S MAIDEN NAME <b>Jennings Deborah J. Warrington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Walter T. Kees, Cockeysville, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema, probable carcinoma of breast with metatasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>55</b> , to <b>Aug. 21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Aug. 20</b> , 19 <b>56</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Sykesville, MD. 8-21-1956</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-23-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 29-56</b>		24b. REGISTRAR'S SIGNATURE <b>Robert R. Hewitt.</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED CARROLL, CAROL ANN		SEX FEMALE	
DATE OF BIRTH JANUARY 1, 1925		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION HOUSEWIFE		PLACE OF DEATH 1000 N. W. 10th St., Baltimore, Md.	
CAUSE OF DEATH MYOCARDIAL INFARCTION		MANNER OF DEATH NATURAL	
DATE OF DEATH SEPTEMBER 4, 1956		TIME OF DEATH 10:15 A.M.	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF REGISTRAR J. Edgar Hoover	
ADDRESS OF DECEASED 1000 N. W. 10th St., Baltimore, Md.		ADDRESS OF NEXT OF KIN 1000 N. W. 10th St., Baltimore, Md.	
SIGNATURE OF NEXT OF KIN J. Edgar Hoover		SIGNATURE OF WITNESSES J. Edgar Hoover	

BUREAU V. S.

SEP 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8185

## CERTIFICATE OF DEATH

08159

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>401 S. Gilmer St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>KESSLER</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailorress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
13. FATHER'S NAME <b>Joseph Kessler</b>		14. MOTHER'S MAIDEN NAME <b>Betta Frieman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary tuberculosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, hebephrenic type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1950</b> , to <b>August 16, 1956</b> , that I last saw the deceased alive on <b>August 16, 1956</b> , and that death occurred at <b>11:05 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/16/56</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		DATE SIGNED <b>8/16/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		ADDRESS <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		24a. REC'D BY REGISTRAR DATE <b>8/16/56</b>	
ADDRESS <b>2100 Brittain Place</b>		24b. REGISTRAR'S SIGNATURE <b>Harry Keen</b>	

BUREAU A. E.

AUG 20 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188160

8186

## CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Carroll</b>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>X</b> TOWN <b>Rural-Sykesville</b>		LENGTH OF STAY (in this place) <b>5 mo</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural *Westminster</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>90</b> <b>Linger Nursing Home</b>		STREET ADDRESS (If rural give location) <b>R.D. # 6</b>					
3. NAME OF DECEASED: (First) (Middle) (Last) <b>THOMAS H. KOONTZ</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>8 22 1956</b>			
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH: <b>12-16-1879</b>	9. AGE last birthday <b>76</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic retired Garage</b>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>John Thomas Koontz</b>				14. MOTHER'S MAIDEN NAME: <b>Sushanna Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>lost</b>		17. INFORMANT & ADDRESS: <b>6806 Old Harford Rd</b> <b>Mrs. Mabel Koontz, Balto. 14, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebral embolus</b>						<b>10 minutes</b>	
ANTECEDENT CAUSE (B) <b>Cardiac failure</b>						<b>3 weeks</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Generalized arteriosclerosis &amp; nephrosclerosis</b>						<b>15 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>C.V.A &amp; residual hemiplegia</b>						<b>3 years</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-12, 1956</b> , to <b>8-20, 1956</b> , that I last saw the deceased alive on <b>8-20, 1956</b> , and that death occurred at <b>10:35 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Bertrand R. Goss</b>				ADDRESS <b>Sykesville Md</b>		DATE SIGNED <b>8-22-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>8-24-1956</b>		NAME OF CEMETERY OR CREMATORY <b>St. James</b>		LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Aug 23, 1956</b>		REGISTRAR'S SIGNATURE <b>Robert R. Hewitt</b>		24. FUNERAL DIRECTOR <b>C. M. Waltz</b>		ADDRESS <b>Winfield, Maryland</b>	

BUREAU V. S.

1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8187 CERTIFICATE OF DEATH

08161  
74  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3y; 5mos; 10days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3y 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3908 Canterbury Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>KOVACK</b> Last <b>KOVACK</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>63 2 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Michael Kovack</b>		14. MOTHER'S MAIDEN NAME <b>Mary -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield State Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of tonsil</b> <b>145X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc with dist. of metabolism, growth or nutrition, presenile brain disease, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25, 1953</b> , to <b>August 5, 1956</b> , that I last saw the deceased alive on <b>August 4, 1956</b> , and that death occurred at <b>1:00A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		DATE SIGNED <b>8/6/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lashedra</b>		22d. LOCATION (City, town, or county) (State) <b>Old Frederick PA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lohman</b>		24a. REC'D BY REGISTRAR <b>Aug 8 1956</b>	
ADDRESS <b>1318 Light</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 15, 1955		10:00 AM	
Occupation		Manner of Death		Signature of Physician		Signature of Registrar	
Teacher		Natural		[Signature]		[Signature]	
Usual Residence		Place of Death		Hospital or Institution		Name of Hospital	
123 Main St, Baltimore		Home		St. Mary's Hospital		St. Mary's Hospital	
Marital Status		Previous Illnesses		Date of Last Examination		Physician's Name	
Married		Hypertension		Jan 10, 1955		Dr. J. Smith	
Date of Marriage		Date of Admission		Date of Discharge		Date of Death	
Jan 1, 1935		Jan 10, 1955		Jan 15, 1955		Jan 15, 1955	
Date of Death		Time of Death		Place of Death		Cause of Death	
Jan 15, 1955		10:00 AM		Home		Heart Disease	
Manner of Death		Signature of Physician		Signature of Registrar		Date of Death	
Natural		[Signature]		[Signature]		Jan 15, 1955	

BUREAU V. B.

AUG 8 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8188 CERTIFICATE OF DEATH

08162

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>9mos.; 12days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1614 Portugal Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Stanley</b> Middle <b>KOWALSKI</b> Last <b>KOWALSKI</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>13</b> Year <b>1956</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8 1881</b> 9. AGE (In years last birthday) <b>75 2</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Team driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Francis Kowalski</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosalie Lisnenska</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital records</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic cardiovascular dis.</b> Years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome asso. with cerebral arteriosclerosis with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<b>21. I certify that I attended the deceased from <u>Nov. 1,</u> 19<u>55</u>, to <u>August 13</u>, 19<u>56</u>, that I last saw the deceased alive on <u>August 13</u>, 19<u>56</u>, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.</b>								
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>8/14/56</b>		
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>aug 17/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto County</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Weber</b>				ADDRESS <b>401 S. Chester St</b>		24a. REC'D BY REGISTRAR <b>DATE 8/15/56</b>		
24b. REGISTRAR'S SIGNATURE <b>C. Harry Myers</b>								

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1900	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md		Heart Disease		Aug 10, 1945		10:30 AM	
Occupation		Physician's Name		Hospital Name		Place of Death	
Teacher		Dr. J. H. Smith		St. Mary's Hospital		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 16 1953

RECEIVED

Reg. Dist. No. 08163 74

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore County</u></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>15y; 10mo. 3days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>510 Wilson Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>20</u> Year <u>1956</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 8, 1891</u>
<b>9. AGE</b> (In years last birthday) <u>65</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Massachusetts</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Jacob Jacobson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Pelandeo</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Springfield Hospital records</u>	
<b>17. INFORMANT</b> <u>Springfield Hospital records</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Septicemia</u> DUE TO (c) <u>Abscess in right thigh</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>Hours</u> <u>Weeks</u> <u>Weeks</u>	
<b>21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Schizophrenia, paranoid type</u>		<b>22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>23. TIME OF INJURY</b> Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.		<b>24. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>25. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Springfield State Hospital</u>		<b>26. (City or town)</b> <u>Sykesville</u>	
<b>27. (County)</b> <u>Carroll</u>		<b>28. (State)</b> <u>Maryland</u>	
<b>29. I certify that I attended the deceased from</b> <u>July 1, 1950</u> , <b>to</b> <u>August 20, 1956</u> , <b>that I last saw the deceased alive on</b> <u>August 20, 1956</u> , <b>and that death occurred at</b> <u>5:20 P.M.</u> , <b>from the causes and on the date stated above.</b>			
<b>30. ACTUAL SIGNATURE</b> <u>Walther H. Sonnenfeldt</u>		<b>31. ADDRESS</b> (Street, city or town, state) <u>Springfield State Hospital</u>	
<b>32. PHYSICIAN'S NAME (Type)</b> <u>Walther H. Sonnenfeldt, M.D.</u>		<b>33. DATE SIGNED</b> <u>8/21/56</u>	
<b>34. PHYSICIAN'S NAME (Type)</b> <u>Walther H. Sonnenfeldt, M.D.</u>		<b>35. ADDRESS</b> <u>Sykesville, Maryland.</u>	
<b>36. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>37. DATE THEREOF</b> <u>Aug 24th 1956</u>	
<b>38. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cemetery</u>		<b>39. LOCATION</b> (City, town, or county) (State) <u>Ea stern Blvd. Balto Co. Md.</u>	
<b>40. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John G. Connelly</u>		<b>41. ADDRESS</b> <u>Essex, Md.</u>	
<b>42. REC'D BY REGISTRAR</b> <u>Aug 22 1956</u>		<b>43. REGISTRAR'S SIGNATURE</b> <u>C. Harry Harris</u>	



CERTIFICATE OF DEATH

41 22

<p>1. Name of deceased: <b>JOHN J. CAMPBELL</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>1911</b></p>		<p>4. Age: <b>45</b></p>	
<p>5. Place of birth: <b>NEW YORK</b></p>		<p>6. Race: <b>White</b></p>	
<p>7. Usual residence: <b>1111 Madison Avenue</b></p>		<p>8. Cause of death: <b>Heart Disease</b></p>	
<p>9. Date of death: <b>Aug 22 1956</b></p>		<p>10. Time of death: <b>10:00 AM</b></p>	
<p>11. Place of death: <b>Home</b></p>		<p>12. Signature of physician: <b>JOHN J. CAMPBELL</b></p>	
<p>13. Signature of registrar: <b>JOHN J. CAMPBELL</b></p>		<p>14. Signature of informant: <b>JOHN J. CAMPBELL</b></p>	
<p>15. Date of registration: <b>Aug 22 1956</b></p>		<p>16. Place of registration: <b>Baltimore</b></p>	
<p>17. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>18. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>19. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>20. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>21. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>22. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>23. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>24. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>25. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>26. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>27. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>28. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>29. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>30. Address of informant: <b>1111 Madison Avenue</b></p>	
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<p>39. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>40. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>41. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>42. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>43. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>44. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>45. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>46. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>47. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>48. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>49. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>50. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>51. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>52. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>53. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>54. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>55. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>56. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>57. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>58. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>59. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>60. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>61. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>62. Address of informant: <b>1111 Madison Avenue</b></p>	
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<p>69. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>70. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>71. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>72. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>73. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>74. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>75. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>76. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>77. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>78. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>79. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>80. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>81. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>82. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>83. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>84. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>85. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>86. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>87. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>88. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>89. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>90. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>91. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>92. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>93. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>94. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>95. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>96. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>97. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>98. Address of informant: <b>1111 Madison Avenue</b></p>	
<p>99. Name of informant: <b>JOHN J. CAMPBELL</b></p>		<p>100. Address of informant: <b>1111 Madison Avenue</b></p>	

RECEIVED

AUG 22 1956

BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8190

## CERTIFICATE OF DEATH

08164

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>5421 Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Henry, Jr.</b> Last <b>LITTLE</b>			4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1875</b>		9. AGE (In years last birthday) yrs. <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbers' helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Henry Little, Sr.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
14. MOTHER'S MAIDEN NAME <b>Clarabel Causey</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		
16. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT Address <b>Springfield Hospital records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Pulmonary embolism</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prostatectomy</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with senile changes.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 17, 1956</b> , to <b>August 21, 1956</b> , that I last saw the deceased alive on <b>August 21, 1956</b> , and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>8/21/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 25/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons</b>		ADDRESS <b>2024 Orleans St. 31</b>		24a. REC'D BY REGISTRAR <b>AUG 22 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. H. H. H. H. H.</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED HARRIS, JAMES		AGE 45		SEX Male		RACE White		DATE OF BIRTH April 15, 1910		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		OCCUPATION Carpenter		EDUCATION High School		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH April 25, 1956		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED James Harris		SIGNATURE OF WITNESSES John Doe, Jane Doe	
DATE OF REPORT April 26, 1956		PLACE OF REPORT Home		TIME OF REPORT 11:00 AM		SIGNATURE OF REPORTER J. H. Smith		SIGNATURE OF DECEASED James Harris		SIGNATURE OF WITNESSES John Doe, Jane Doe	

BUREAU V. 1

JUN 23 1956

RECEIVED

8191

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>				d. STREET ADDRESS <b>RURAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JAMES ALLEN MAGRUDER</b>				4. DATE OF DEATH <b>AUG 2 1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COL.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT-26-1952</b>		9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>RUTH LOUISE MAGRUDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RUTH L. MAGRUDER, NEW WINDSOR MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro Intestinal disorder</b> <b>544.2</b> DUE TO <b>follow with convulsions</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8-2-1956</b> , to <b>8-2-1956</b> , that I last saw the deceased alive on <b>Aug 2 1956</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. H. Legg e</b>				ADDRESS (Street, city or town; state) <b>Union Bridge, Md.</b>			
PHYSICIAN'S NAME (Type) <b>T. H. LEGG MD</b>				DATE SIGNED <b>Aug 6 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>AUG 5-56</b>		<b>WESTERN CHAPEL</b>		<b>WESTMINSTER RURAL MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DR. Barker &amp; Sons, New Windsor, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE Aug 6 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Anna S. Bunch</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU A. I.

AUG 13 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8192

CERTIFICATE OF DEATH

08166  
 Reg. Dist. No. 745

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster, Route 5</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1956</b>			
3. NAME OF DECEASED (Type or print) <b>Bessie Louise Pickett MARING</b>		First Middle Last		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 25, 1908</b>		9. AGE (In years lost birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Pickett</b>				14. MOTHER'S MAIDEN NAME <b>Florence Conway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-4614</b>		17. INFORMANT <b>Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Breast lung</b> DUE TO (b) <b>Metastasis of breast cancer</b> DUE TO (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield Hospital</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>May 17, 1956</b> to <b>August 16, 1956</b> , that I last saw the deceased alive on <b>August 15, 1956</b> , and that death occurred at <b>12:40A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				DATE SIGNED <b>8/16/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Winfield Church of God</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. M. Waltz</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>8/16/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Henry J. ...</b>							

CERTIFICATE OF DEATH

1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1865		Maryland		Baltimore		Heart Disease		Baltimore		10:30 AM		J. H. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Previous Illness		Previous Injuries	
Teacher		Yes		No		No		No		White		Caucasian		Roman Catholic		High School		None		None	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Place of Death	
Aug 21, 1910		10:30 AM		Baltimore		Heart Disease		Baltimore		10:30 AM		Baltimore		Heart Disease		Baltimore		10:30 AM		Baltimore	

BUREAU V. S.

Aug 21 1910

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 1c, 21 Film G203 9-14-56 et  
8193  
CERTIFICATE OF DEATH

08167

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 Mos. 2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b>		1616.25	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>4200 29 th Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Burton</b> Middle <b>William</b> Last <b>Markward</b>		4. DATE OF DEATH Month <b>8</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-86</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Markward</b>		14. MOTHER'S MAIDEN NAME <b>Belle Hutchinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-03-4077</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebr. arterioscler. with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2-23-56</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 27, 1955</b> to <b>Aug. 24, 1956</b> , that I last saw the deceased alive on <b>Aug. 24, 1956</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Julian Radzykewycz</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>JULIAN RADZYKEWYCZ</b>		DATE SIGNED <b>8-25-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/28/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaskin</b>		24a. REC'D BY REGISTRAR <b>Hyattsville</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry New</b>		DATE <b>8/27/56</b>	

CERTIFICATE OF DEATH

1956

COUNTY OF BALTIMORE DISTRICT OF BALTIMORE		DECEASED NAME JOHN J. BROWN	
SEX MALE		AGE 68	
DATE OF BIRTH 1911		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION RETIRED		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH 1956	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CORONER (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF CLERK (If known)	

RECEIVED

1956

08168

# CERTIFICATE OF DEATH

Reg. Dist. No.

8194

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>1 mo., 9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>		<b>15X-2</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>111 Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Osborn McCATHRAN</b>				4. DATE OF DEATH Month Day Year <b>August 19, 1956</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6, 1889</b>					
9. AGE (In years (or birthday) yrs.) <b>67</b>		10. AGE (In years (or birthday) yrs.) <b>67</b>		11. AGE (In years (or birthday) yrs.) <b>67</b>		12. AGE (In years (or birthday) yrs.) <b>67</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Albert Osborn</b>				14. MOTHER'S MAIDEN NAME <b>Phebe Jane Rosencrantz</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital records</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia</b> DUE TO (c) <b>Decubitus ulcers</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Weeks</b> <b>Weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to cerebral arteriosclerosis with psychosis</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1956</b> , to <b>August 19, 1956</b> , that I last saw the deceased alive on <b>August 19, 1956</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>				DATE SIGNED <b>8/20/56</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland							
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <b>8/22/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md</b>					
DIRECTOR'S SIGNATURE <b>W. C. Gaither, Gaithersburg Md</b>				ADDRESS <b>Gaithersburg Md</b>		24a. REC'D BY REGISTRAR <b>8/23/56</b>		24b. REGISTRAR'S SIGNATURE <b>Harry H. H.</b>			



CERTIFICATE OF DEATH

9121

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1965		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Married		Single		Widowed		Divorced		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1965		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Married		Single		Widowed		Divorced		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive		Last Seen Alive	

BUREAU V. S.

JUN 2 1965

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. No. 8169 74

8195

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 yr - 6 Mo</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hosp.</b>				e. STREET ADDRESS <b>Sykesville, MD.</b>			
3. NAME OF DECEASED (Type or print) <b>JANE</b> First Middle Last <b>AGNES McCONNELL</b>				4. DATE OF DEATH <b>August 17 1956</b> Month Day Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-24-1865</b> 9. AGE (In years last birthday) <b>91</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McConnell</b>				14. MOTHER'S MAIDEN NAME <b>JANE McCONNELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>303 Murdock Rd. Baltimore, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Genl. Arterio Sclerosis</b> (c) <b>12 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>May 19 1953</b> to <b>Aug 17 1956</b> that I last saw the deceased alive on <b>Aug 17 1956</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Martin</b> M.D.				ADDRESS (Street, city or town, state) <b>Sykesville Md 21751</b> DATE SIGNED <b>11/7/56</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New (Ethneal)</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Dickmeyer Sons</b> ADDRESS <b>1014 Baltimore</b>				24a. REC'D BY REGISTRAR <b>11-15-56</b> DATE		24b. REGISTRAR'S SIGNATURE <b>C. Harry Kuep</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. McMANUS</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 21 1956</i>		5. TIME OF DEATH <i>11:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. SIGNATURE OF DECEASED <i>None</i>	
16. SIGNATURE OF NEXT OF KIN <i>None</i>		17. SIGNATURE OF PHYSICIAN <i>None</i>		18. SIGNATURE OF REGISTRAR <i>None</i>	
19. SIGNATURE OF COUNTY CLERK <i>None</i>		20. SIGNATURE OF STATE CLERK <i>None</i>		21. SIGNATURE OF DEPARTMENT CLERK <i>None</i>	

BUREAU V. S.

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8196

## CERTIFICATE OF DEATH

08170

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>312 W. Camden St., Balto.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Smith</b> Last <b>MELVIN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1912</b>
9. AGE (In years last birthday) yrs. <b>44</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall Melvin</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute interstitial pneumonia</b> 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A.B.S. due to alcoholic intox., D.T.'s, C.B.S. due to alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30</b> , 19 <b>56</b> , to <b>August 10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 9</b> , 19 <b>56</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/10/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/12/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro N. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Dickerson</b>		ADDRESS <b>N. A. Balto. 12, Md.</b>	
24a. REC'D BY REGISTRAR <b>August 11, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>R. W. C. Harry Sharp</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH, 18

08171

8197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cumall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cumall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hicksburg (Rural)</u> - 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hicksburg (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WALTER- N-MUMMAUGH</u>		4. DATE OF DEATH <u>Aug 8</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 6 - 1892</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicholas Mummaugh</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Schilling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>270-34-6102</u>	
17. INFORMANT <u>Mrs Alfred Daugherty-Hicksburg Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Liver</u> DUE TO 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November</u> , 19 <u>55</u> , to <u>Aug, 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 8</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>8/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emory</u>	22d. LOCATION (City, town, or county) (State) <u>Cumall so Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Stipton</u>		24a. REC'D BY REGISTRAR <u>Hampstead Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Hampstead Md</u>		24c. REC'D BY REGISTRAR <u>5-10-56</u>	
24d. REGISTRAR'S SIGNATURE <u>Hampstead Md</u>		24e. REGISTRAR'S SIGNATURE <u>Hampstead Md</u>	

MAHARAJA STATE COLLEGE

BUREAU V. B.

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08172 74  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>11 mos.; 9 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1934 N. Patterson Park Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Francis</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1911</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William C. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Loretta Sanner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield State Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging by neck</b> <b>974X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, chronic undifferentiated type</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hung himself</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:05 p.m. 8/16/ 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/16/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 26 1956</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Bldg</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leo Gilasch</b>		ADDRESS <b>170103 N. Patterson Park Ave</b>	
24a. REC'D BY REGISTRAR <b>Aug. 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Jones</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
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BUREAU V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8157

## CERTIFICATE OF DEATH

08173

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN 1b <b>6 wks.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>79 John Street</b>		d. STREET ADDRESS <b>R.D. # 6</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES H. NINER</b>		4. DATE OF DEATH <b>AUGUST 2, 1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-1865</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Niner</b>		14. MOTHER'S MAIDEN NAME <b>Fredericka Swope</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Carrie Stimax, 79 John St. Westminster Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerosis</b> DUE TO (c) <b>senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute respiratory infection (virus)</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1<sup>st</sup>, 1946</b> , to <b>Aug. 2<sup>nd</sup>, 1956</b> , that I last saw the deceased alive on <b>Aug. 1<sup>st</sup>, 1956</b> , and that death occurred at <b>1308</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. L. Billingslea</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>8-3-56</b>	
PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>		<b>Westminster, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-5-1956</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Trinity Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b> ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>8-6-56</b> 24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>	



BUREAU V. S.

AUG 8 1956

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8199

CERTIFICATE OF DEATH

08174

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>R</b> Last <b>Ohler</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 4, 1872</b>		9. AGE (In years last birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel S. Null</b>				14. MOTHER'S MAIDEN NAME <b>Mary I. Fair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Raymond J. Ohler</b>		Address <b>Taneytown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive-arteriosclerotic</b> DUE TO (c) <b>Cardiovascular Renal disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>  <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>6/22</b> , 19 <b>56</b> , to <b>8/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/14</b> , 19 <b>56</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles R Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Emmitsburg Md</b>			
DATE SIGNED <b>8/28/56</b>							
PHYSICIAN'S NAME (Type) <b>Charles R Williams</b>				ADDRESS <b>Emmitsburg Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Aug. 31, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mervyn C Fuss</b>				ADDRESS <b>Taneytown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>aug 31/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ethel M Mehning</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8200

## CERTIFICATE OF DEATH

08175

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>10/24/55</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Thomas</i> Last <i>Padian</i>		4. DATE OF DEATH Month <i>August</i> Day <i>11</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/13/1877</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Road Worker Railroad - Penn.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Padian</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Padian (nee Kelly)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Records of Springfield State Hospital</i>		Address <i>Sykesville, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Bronchopneumonia</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General - Arteriosclerosis, Hypotension</i> DUE TO <i>10 years</i> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome with toxic brain disease with psychotic reaction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>8/11</i> 19 <i>56</i> , to <i>8/11</i> 19 <i>56</i> , that I last saw the deceased alive on <i>8/11</i> 19 <i>56</i> , and that death occurred at <i>11:15 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE <i>Edmund Lusthaus</i> M.D. <i>SPRINGFIELD STATE HOSP.</i>		DATE SIGNED <i>8/11/56</i>	
PHYSICIAN'S NAME (Type) <i>EDMUND LUSTHAUS SYKESVILLE, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/14/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Maria Cemetery</i>	22d. LOCATION (City, town, or county) <i>Towson, Maryland</i> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>		24a. REC'D BY REGISTRAR <i>Aug 14 1956</i> 24b. REGISTRAR'S SIGNATURE <i>C. Harry Hays</i>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8201 CERTIFICATE OF DEATH

08176  
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>2 y 6 mo 23 d</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED First <i>Lillian</i> Middle <i>Violet</i> Last <i>Reynolds</i>		4. DATE OF DEATH Month <i>8</i> Day <i>13</i> Year <i>19 56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-30-71</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Isaac Clay</i>		14. MOTHER'S MAIDEN NAME <i>Elisa Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. with senile changes in the brain with psychosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 28.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July-23, 19 56</i> to <i>August-13, 19 56</i> , that I last saw the deceased alive on <i>August-12, 19 56</i> , and that death occurred at <i>3:21 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		DATE SIGNED <i>8/13/56</i>	
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>8/15/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Crem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner</i>		24a. REC'D BY REGISTRAR <i>Aug 14 1956</i>	
ADDRESS <i>Balto. Md.</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Thayer</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1921		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APRIL 4, 1968		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.		APRIL 4, 1968		MEMPHIS		TENNESSEE		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
SHOOTING		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		SHOOTING		SUICIDE		ATTORNEY		HIGH SCHOOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
JUN 15 1968  
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8202

## CERTIFICATE OF DEATH

0921874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>44y; 5mos. 24da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) <b>James ROBERTS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884</b>		9. AGE (In years lost birthday) <b>72</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Springfield Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>Years</b>  <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia Praecox - Hebephrenic type</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1950</b> , to <b>August 30, 1956</b> , that I last saw the deceased alive on <b>August 29, 1956</b> , and that death occurred at <b>6:35A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		M.D. <b>Springfield State Hospital</b>				DATE SIGNED <b>8/30/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board, U. of M.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 7 1956</b>	
						24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. HENRY		AGE 45		SEX Male		RACE White		DATE OF DEATH July 1, 1950	
PLACE OF BIRTH Boston, Mass.		DATE OF BIRTH June 15, 1905		OCCUPATION Carpenter		MARITAL STATUS Married		EDUCATION High School	
RESIDENCE 123 Main St., Boston, Mass.		DATE OF DEATH July 1, 1950		HOURS OF DEATH 10:30 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		COMPLICATIONS None		POST-MORTEM None	
SIGNATURE OF PHYSICIAN J. J. Smith, M.D.		SIGNATURE OF REGISTRAR J. J. Smith		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF DECEASED None	
DATE OF SIGNATURE July 1, 1950		DATE OF SIGNATURE July 1, 1950		DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	

BUREAU V. S.

SEP 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8203

## CERTIFICATE OF DEATH

Reg. Dist. No.

0817874

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1816 Fleet St., Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Irene</b> Last <b>SPATURA</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1889</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-01-3817</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 17</b> , 19 <b>56</b> , to <b>August 6</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 6</b> , 19 <b>56</b> , and that death occurred at <b>2:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/7/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 10, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>		24. REGISTRAR'S SIGNATURE <b>C. Harry Myers</b>	



RECEIVED

AUG 10 1956

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8204

## CERTIFICATE OF DEATH

Reg. Dist. No.

83

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>Ridge Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Spurrier</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Weishaar</u>		14. MOTHER'S MAIDEN NAME <u>Mary Angeline Reaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>(If yes, give war or dates of service)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>30 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>Aug</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 17</u> , 19 <u>56</u> , and that death occurred at <u>8:02</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Mt. Airy, Md.</u> <u>Aug 17, 1956</u>			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		M.D. <u>W.B. Culwell</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-19-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marvin Chapel Cmty</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. Shewell</u>	

**BUREAU V. S.**

AUG 20 1956

RECEIVED

8205

CERTIFICATE OF DEATH

08180

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>24y., 6mos., 5days</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>19 N. Monroe Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Agnes</b> Last <b>STARRY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland BALTO.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK AT HOME</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry W. Starry</b>		14. MOTHER'S MAIDEN NAME <b>Mary T. Langan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelitis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>2 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Convulsive disorder with psychosis.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1950</b> , to <b>August 17, 1956</b> , that I last saw the deceased alive on <b>August 16, 1956</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>8/17/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/20/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park, Conn</b>	22d. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Gowan</b>		ADDRESS <b>99 Locust St</b>	
24a. REC'D BY REGISTRAR <b>Aug. 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Stary</b>	

# CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		TAMPA, FLORIDA		TAMPA		UNITED STATES OF AMERICA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES OF AMERICA		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES OF AMERICA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
FIREARM WOUND TO THE CHEST		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
PHYSICIAN'S SIGNATURE		DATE OF SIGNATURE		HOSPITAL		CITY		STATE		COUNTRY		CITY		STATE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	
FAMILY PHYSICIAN		DATE OF SIGNATURE		HOSPITAL		CITY		STATE		COUNTRY		CITY		STATE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	
CORONER'S SIGNATURE		DATE OF SIGNATURE		HOSPITAL		CITY		STATE		COUNTRY		CITY		STATE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	
FAMILY PHYSICIAN		DATE OF SIGNATURE		HOSPITAL		CITY		STATE		COUNTRY		CITY		STATE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	

BUREAU V. 2

AUG 26 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0818176

8158

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Westminster Md - Carroll</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Park Rd - Westminster Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer Park Road</u>		d. STREET ADDRESS <u>Deer Park Road</u>	
3. NAME OF DECEASED (Type or print) <u>Fannie Maud</u> First <u>Stimmel</u> Middle <u>Stimmel</u> Last <u>Stimmel</u>		4. DATE OF DEATH <u>Aug 9</u> 19 <u>56</u> Month <u>Aug</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Feb. 6, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Jacob Stimmel</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Miss Bertha Guise, Spring Grove State Hosp</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>Sarah Cookerly</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> <u>174X</u> DUE TO <u>metastasis to liver + lungs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>✓</u> (c) <u>✓</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1-54</u> , 19 <u>54</u> , to <u>8-9-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-8-56</u> , 19 <u>56</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield Md</u> DATE SIGNED <u>James G. Saffell</u> ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) <u>James G. Saffell</u> <u>Reston Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wible</u>		ADDRESS <u>4101 Edmondson Ave</u>	24a. REC'D BY REGISTRAR DATE <u>8/13/56</u>
		24b. REGISTRAR'S SIGNATURE <u>Harriet Mulvey</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>	
5. PLACE OF BIRTH <i>John Doe</i>		6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1935</i>	
9. PLACE OF DEATH <i>John Doe</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. DATE OF DEATH <i>Aug 14 1956</i>	
13. SIGNATURE OF PHYSICIAN <i>John Doe</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. 3

AUG 14 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8206

## CERTIFICATE OF DEATH

Reg. Dist. No.

081824

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 23</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>480 S. Bentalou Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Stolte</b> Last <b>Stolte</b>		4. DATE OF DEATH Month <b>8</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>barber</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard Stolte</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Berer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebral arterioscler. with psych. reaction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20, 1954</b> , to <b>Aug. 21, 1956</b> , that I last saw the deceased alive on <b>Aug. 21, 1956</b> , and that death occurred at <b>8:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8-21-56</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>		<b>Sykesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>8-23-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsonage</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. B. Kippert</b>		ADDRESS <b>1300 Eutaw Pl.</b>	
24a. REC'D BY REGISTRAR <b>8-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Hens</b>	

## MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

AUG 24 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08183  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt Airy</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Branch of Patapsco River</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Larry</i> Middle <i>Morris</i> Last <i>Twenty</i>				4. DATE OF DEATH Month <i>August</i> Day <i>9</i> Year <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 11, 1942</i>	
9. AGE (In years last birthday) <i>13</i> yrs.		IF UNDER 1 YEAR Months <i>13</i> Days <i>13</i>		IF UNDER 24 HRS. Hours <i>13</i> Min. <i>13</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>High School Student</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Frederick, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Amos O. Twenty, Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Mary Emma Burdette</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Amos O. Twenty, Sr., Mt. Airy, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Accidental drowning</i> <i>929.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Patapsco River</i>		20f. (City or town) (County) (State) <i>Carroll</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>B. O. Thomas</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>August 9, 1956</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 11, 1956</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Damascus Meth.</i>		22d. LOCATION (City, town, or county) (State) <i>Damascus, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Moleworth</i> ADDRESS <i>Damascus, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>8-11-56</i>		24b. REGISTRAR'S SIGNATURE <i>Robert R. Hewitt</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner	
John O. Twenter, Sr.		45		Male		White		Jan 1, 1900		Jan 14, 1945		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Injury		Suicide		Other	
2000 Broadway		Teacher		High School		Married		None		Occasional		Daily		None		None		None		None	
City		State		Country		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Boston		Mass.		U.S.A.		Catholics		Jan 15, 1945		10:00 AM		Catholics		Jan 15, 1945		10:00 AM		Catholics		Jan 15, 1945	

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AUG 14 1945  
BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
JUL 11 1945  
BOSTON, MASS.